Texas Department of Aging and Disability Services

State Long-term Care Ombudsman Program

Certified Ombudsman II Recommendation and Approval

Form 8610
November 2012

I recommend _____ for promotion to certified ombudsman II for the Texas Department of Aging and Disability Services Long-term Care Ombudsman Program. As managing local ombudsman for the _____ Ombudsman Program or as state long-term care ombudsman:

I certify this individual has met the following mandatory requirements:

- ☐ maintained a minimum of two years of active status;*
- ☐ completed 24 hours of continuing education over the course of the previous two fiscal years;
- ☐ completed Ombudsman Certification Training, September 2011 edition, including all exercises and activities;
- ☐ conducted ombudsman case work on a majority of monthly reports, including:
  - ☐ identification and receipt of ombudsman complaints;
  - ☐ demonstration of independence in investigating and working to resolve complaints; **and**
  - ☐ coordination with supervising staff ombudsman, in accordance with procedures, to resolve complaints;
- ☐ submitted monthly reports of ombudsman activities for 20 of the last 24 months; **and**
- ☐ demonstrated professionalism and service as a role model for certified ombudsmen by:
  - ☐ engaging in systems advocacy at facility, local area or statewide levels;
  - ☐ demonstrating leadership during training; **or**
  - ☐ training or mentoring ombudsman interns and newly certified ombudsmen.

I have reviewed, evaluated, and validated completion of written responses to the:

- ☐ Ombudsman Certified Training Chapter exercise; and
- ☐ Getting Acquainted with Ombudsman Policies and Procedures exercise.

(Retain these documents in the individual's file at the local ombudsman program office)

I recommend promotion to certified ombudsman II.

_____ _____
Signature— Managing Local Ombudsman Date

I approve promotion to certified ombudsman II.

_____ _____
Signature— State Long-term Care Ombudsman or designee Date

State Office Use

CO II Certification date _____

OmbudsManager updated on _____ *by* _____

Recertification month/year: _____ *(recertification required every two years)*

Mail original to:

State Long-term Care Ombudsman
Texas Department of Aging and Disability Services
P. O. Box 149030, MC – W250, Austin, Texas 78714

*To be active, an individual must be certified, perform facility visits, and report activity to the local ombudsman program. OPPM 700